PRINTED: 11/02/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1001	A. BUILDING 01 - MAIN BUILDING 01 B. WING:	10/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE HEALTH CENTER	1633 HILLVIEW DRIVE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey conducted on October 31, 2011, no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002	2. Environmental Supervisor ensured on 10/31/11 that all oxygen concentrators and bed/air pumps (medical devices) were directly plugged to the wall receptacle. 3. Environmental Supervisor was inserviced on 11/8/11 regarding state and federal requirements on the use of extension cords and multiple outlet adapters. 4. The weekly maintenance schedule has been revised to include all medical devices to ensure Oxygen Concentrators and bed/air pumps are directly plugged into wall receptacles. Environmental Supervisor will report results to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will review maintenance logs for 3 months and/or until 100% in compliance. The Quality Assurance Performance Improvement Committee is comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Resident Assessment Nurses, Social Services, Activities Director, Dietary Manager, Environmental Supervisor and Rehab Manager.	

Division of Health Care Facilities

Joanne Barker, Administrator — TITLE — (X6) DATE 11/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE